AccuReview

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Notice of Independent Review Decision

[Date notice sent to all parties]: January 27, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Sacroilliac Injection 27096 77003

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

This physician is Board Certified in Orthopaedic Surgery with over 14 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a female who reported an injury on xx/xx/xx . The mechanism of injury was a fall. The claimant injured her lower back when she slipped on the floor that a student spilled and landed on her coccyx with her right knee flexed behind her. She strained her right ankle and low back.

07-10-14: Visit Note-PT. CC: Claimant complains of pain and discomfort located over the lower back and right ankle. The precipitating event was a fall (wet floor). She described it as aching, dull, sharp and shooting pain that are frequent (50-75%). Discomfort is mild-moderate in nature. She feels better with rest and worse with any activity or movement or sitting, 2/10 currently and 6-7/10 when it's at it's worst. Current medications: Flexeril 10mg and Naprosyn EC 500mg. PE: Lumbar Examination: On examination of the lumbar spine, AROM are restricted in: restricted flexion, extension, left rotation, right rotation, left lateral flexion, right lateral flexion. There is tenderness on palpation over L3, L4, L5, S1, the sacrum

and right sacroiliac joint. Kemp's test is positive on both the sides of the lumbar region. Yeoman's is positive on both the sides of lumbar region. Nachlas' test is positive on the left side of lumbar region. Procedures: PT Evaluation. 724.2 Lumbago. Plan: Cold packs 30 minutes on and one hour off 2-3x daily. Treatment plan will consist of 3x a week for 4 weeks plus two visits for a total of 14 visits. Goals are to decrease pain and tenderness while increasing ROM and strength. Claimant will be given home exercises.

07-24-14: Visit Note-Office Visit. CC: Claimant complained of musculoskeletal pain, first noted on xx/xx/xx, with sudden onset, occurred frequently and has been improving over time. Pain is located in the lower back and right ankle, sharp and aggravated with certain movements. Current medications: Flexeril 10 mg, Naprosyn EC 500mg. PE: Musculoskeletal: Spine: Lumbar spine: ROM is restricted with flexion limited to 80 degrees, extension limited to 25 degrees, right lateral bending limited to 35 degrees, left lateral bending limited to 45 degrees, lateral rotation to the left limited to 70 degrees and lateral rotation to the right limited to 70 degrees. Back movements are painful with flexion. Paravertebral muscles are normal. DX: 724.2 Lumbago. Plan: F/U after 1 week, continue PT, full duty: return to work without restrictions. Claimant is improving as expected and stated she is 70% better.

07-31-14: Visit Note-Office Visit. CC: musculoskeletal pain. Current medications: Flexeril 10mg, Naprosyn EC 500mg. PE: Musculoskeletal: Spine: Lumbar spine: ROM is restricted with extension limited to 15 degrees, right lateral bending limited to 20 degrees, back movements are painful with extension and right lateral bending. DX: 724.2 Lumbago. Plan: continue the current drug regimen, request additional PT.

08-13-14: Pre-authorization Request. The following is requested due to claimant's current physical status: physical therapy services. The claimant is in need of continued therapeutic exercises and or therapeutic activities that will maintain/improve flexibility/ROM, strength, stamina, endurance and functional performance through supervised exercises and/or dynamic activities with the provider that will require 60 minutes per treatment session. The frequency and duration of the requested service are for 3x week for 3 weeks for a total of 9 visits, at which time the claimant will be re-evaluated where the claimant's prognosis will and accessed and treatment adjusted if needed.

08-25-14: Visit Note-Office Visit. CC: musculoskeletal pain lower back and right ankle, 2-3/10, dull aggravated factors include bending over, prolonged sitting and standing on an incline. Condition gets better with getting adjusted. PE: Musculoskeletal: Spine: Lumbar spine: ROM is restricted with flexion limited to 80 degrees, extension limited to 25 degrees, right lateral bending limited to 40 degrees, left lateral bending limited to 45 degrees. Back movements are painful with extension. On examination of the paravertebral muscles, hypertonicity is noted on the left side. Structural exam: musculoskeletal exam: lumbar exam shows left rotation L2, L3, L4, L5 tissue is doughy pelvic exam shows ASIS is superior left iliac crest height is superior left sacral exam shows sacral torsion is

left on left. DX: 724.2 Lumbago, 739.3 Somatic Dysfunction of Lumbar Region, 739.4 Somatic Dysfunction of Sacral Region, 739.5 Somatic Dysfunction of Pelvic Region. Plan: F/U after 3 days, continue home exercises.

09-10-14: Functional Capacity Evaluation. CC: low back pain on the right described as an ache, 1/10. Physical Demand Classification: Sedentary/Light. Summary/Recommendations: The claimant completed the FCE with maximum safe effort. She did not exhibit any signs of symptom magnification or malingering. She was able to lift in the medium heavy PDL, and perform the essential functions of her job without pain. She did have sacroiliac pain on right side with stair climbing and sitting. Localized tenderness palpated to the right SI joint. Trunk and extremity mobility is unrestricted. Slight tenderness to both hamstrings was noted with leg raise test. Upper and lower abdominal strength is 75%. Right ankle mobility, balance and strength are normal. She demonstrated hypermobility of right ankle in inversion to both ankles. Recommend she continue on her HEP emphasizing pelvic stabilization exercises and core strengthening and using ice as need for SI joint flare ups. Recommend she limit prolonged sitting to 20 minutes maximum until pain fully resolves.

09-11-14: Pre-authorization Request. We are requesting 9 work conditioning sessions as the claimant is not at MMI.

10-27-14: Designated Doctor Evaluation. Impairment: Whole Person Impairment for Lumbar Injury: 5%. Purpose fo examination: 1. Determine MMI: The claimant is at MMI. She has received the maximum number of chiropractic, PT and work conditioning sessions that the ODG recommend. She received her last therapy visit on 10/13/14, therefore 10/14/14 will be the MMI date. 2. Determine impairment rating: 5% whole person impairment for the Lumbar injury.

11-19-14: Office Visit: New Visit. CC: back pain and leg pain located on the right side that has been going on for 3-6 months, 4/10 pain. Pain is better with heat, cold and massage, worse with sitting, walking, and with physical activity. PE: Paravertebral muscles are tender on the right. Radiology Review: X-Ray lumbar series: There is mild spondylosis throughout. Mild height loss at L5/S1. No sign of instability or fracture. Assessment: mild lumbar spondylosis, Right SI joint dysfunction with positive Faber. Plan: Claimant had some improvement in pain on that side since physical therapy. She does have pain over the right SI joint today. That has not been alleviated with multiple sessions of PT. She is tender to palpation over that area on exam today and has a positive Faber on the right. She does not have any focal neurologic deficits. Discussed further treatment options which include continued PT and chiropractic therapy as she has been doing. Discussed a possible diagnostic SI joint injection. If she should have relief with that injection, she would be a candidate for a SI ablation procedure. The diagnostic injection must happen first however. She understands if she follows to the injection she'll need to keep a pain log. Follow up in 2 months for further review. Problems added in today's visit: Disorder of Sacrum-Sacroiliac Joint 724.6, Lumbosacral Spondylosis without Myelopathy 721.3, M47.817, HTN 401.9. Order's for today's visit: L Spine AP/LET 72100, Office Visit New

Extended 99204, No electronic script sent G8445*, INJ; Sacroiliac Level: XI Right 27096, 77003.26.

12-02-14: UR. Reason for denial: A request is made for right sacroiliac joint injection. FCE on 09/10/14 showed SI pain on the right with localized tenderness. Trunk and extremity was unrestricted. Upper and lower abdominal strength was 75 percent. On 10/24/14 examination she was noted to have mildly positive right Kemp's test, and positive Double Leg Raise test. She was noted to have reached MMI and was given 5 percent whole person impairment for the lumbar spine. On 11/19/14 evaluation, she presented with 4/10 right-sided lower back and buttock pain. Treatments rendered had included 12 PT sessions, 9 work conditioning sessions, and 21 chiropractic therapy sessions with no noted improvements. Lumbar x-rays done on the same day showed mild spondylosis throughout and mild height loss at L5-S1. There was no sign of instability or fracture noted. Examination showed right paravertebral muscle tenderness. Lumbar ROM was full and non-painful. Spinous processes were non-tender. SLR and femoral stretch test was negative bilaterally. Muscle strength, sensation and reflexes were normal. Faber test was positive on the right. There was no clinical evaluation from the requesting providerto support the request. There was no documentation of at least 3 positive orthopedic tests in the recent examination findings to suggest SI joint dysfunction as per guidelines. At this point, the medical necessity of the request has not been substantiated.

12-30-14: UR. Reason for denial: The clinical information submitted for review fails to meet the evidence based guidelines for the requested service. The claimant has diagnoses include disorders of the sacrum/sacroiliac joint and lumbosacral spondylosis without myelopathy. Current medications and surgical history were not provided. The diagnostic studies include an unofficial x-ray of the lumbar spine, performed on 11/19/2014, which revealed mild spondylosis throughout with mild height loss at L5-S1 and no sign of instability or fracture. Other therapies were noted to include unspecified medications, PT, chiropractic therapy, work conditioning, bracing, hot compresses, and home exercises. FCE was performed on 09/10/2014 and revealed the claimant's occupational required performance at the sedentary/light physical demand level. However, the claimant was able to perform essential job functions without pain in the medium/heavy PDL. She was also noted to have sacroiliac pain on the right side during the stair climbing and sitting as well as localized tenderness to palpation to the right sacroiliac joint. On 11/9/2014, the claimant presented with right sided lower back and buttock region pain. The claimant revealed tenderness to palpation of the right lumbar paravertebral musculature and full ROM in the knees, ankles, and feet. She has tenderness to palpation over the right sacroiliac joint region and positive Faber test without any focal neurological deficits. The treatment plan was noted to include continuation of PT and chiropractic, discussion of a diagnostic sacroiliac joint injection, and moving forward with a sacroiliac joint ablation procedure if there is a successful response of relief from the injection. The ODG recommend documented evidence of 3 positive exam findings consistent with sacroiliac joint dysfunction and the injection to be administered under fluoroscopic guidance. The claimant was noted to have participated in PT and a HEP, and the

right sacroiliac joint had a positive Faber test. However, there was a lack of documentation to show failed medication management and only one positive exam finding consistent with sacroiliac joint dysfunction during the clinical visit in 11/2014. Moreover, the request failed to indicate the injection would be performed under fluoroscopy. Therefore, in the absence of this documentation, the guidelines' criteria have not been met. As such, the request is non-certified.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The previous adverse determinations are upheld and agreed upon. The claimant is not indicated for a right sacroiliac (SI) injection. The Official Disability Guidelines (ODG) requires three positive exam findings consistent with SI joint pathology before considering this injection. All other pain generators should be addressed first. The medical records reviewed do not document three positive exam findings consistent with SI joint pathology as a source of pain. Furthermore, the claimant has spondylosis throughout the lumbar spine, with radiographic evidence of disc pathology at L5-S1. It is possible that the patient's complaints could be referred from disease at L5-S1. This potential pain generator should be addressed first. The claimant does not meet ODG requirements for a right SI joint injection. Therefore, the request for Right Sacroilliac Injection 27096 77003 is denied.

Per ODG:

Sacroiliac joint blocks	**Criteria for the use of sacroiliac blocks:** 1. The history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings as listed above). 2. Diagnostic evaluation must first address any other possible pain generators. 3. The patient has had and failed at least 4-6 weeks of aggressive conservative therapy including PT, home exercise and medication management. 4. Blocks are performed under fluoroscopy. (Hansen, 2003) 5. A positive diagnostic response is recorded as 80% for the duration of the local anesthetic. If the first block is not positive, a second diagnostic block is not performed. 6. If steroids are injected during the initial injection, the duration of pain relief should be at least 6 weeks with at least > 70% pain relief recorded for this period. 7. In the treatment or therapeutic phase (after the stabilization is completed), the suggested frequency for repeat blocks is 2 months or longer between each injection, provided that at least >70% pain relief is obtained for 6 weeks. 8. The block is not to be performed on the same day as a lumbar epidural steroid injection (ESI), transforaminal ESI, facet joint injection or medial branch block. 9. In the treatment or therapeutic phase, the interventional procedures should be repeated only as necessary judging by the medical necessity criteria, and these should be limited to a maximum of 4 times for local

	anesthetic and steroid blocks over a period of 1 year.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**